



Deposition of:
Daniel Silcox III, M.D.

August 17, 2016

In the Matter of:
Walker vs. Mac Acquisitions

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1 IN THE UNITED STATES DISTRICT COURT
2 FOR THE NORTHERN DISTRICT OF GEORGIA
3 ATLANTA DIVISION

4 DAVID G. WALKER and
5 SANDRA R. WALKER,
6 Plaintiffs,

Civil Action File No.

7 vs.

1:14-cv-04035-CC

8 MAC ACQUISITION, LLC,
9 Defendant.
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13
14

15 VIDEOTAPED DEPOSITION OF DANIEL H. SILCOX, III, M.D.
16

17 August 17, 2016 - 4:35 p.m.
18

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20

21 Suite 600
22

23 Atlanta, Georgia
24

25 J. David Brown, B-1401

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19 DAVID G. WALKER

20 LISA WILKERSON

21 ADAM KOETTER

22 ERVIN FARKAS, Videographer

1 (Pursuant to Article 10(B) of the Rules
2 and Regulations of the Georgia Board of Court
3 Reporting, a written disclosure statement was
4 submitted by the court reporter to all counsel
5 present at the proceeding.)
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P R O C E E D I N G S

THE VIDEOGRAPHER: This is the videotaped deposition of Dr. Daniel Silcox in the case of David Walker and Sandra Walker versus MAC Acquisition, LLC. Today is Wednesday, August 17th, 2016 and the time is 4:35 p.m. We're now on the video record.

All counsel present, please introduce yourselves and state whom you represent.

MR. DEVINE: My name is Foy Devine and I represent David and Sandy Walker.

MR. BAKER: My name is Kyle Baker. I represent the plaintiffs as well.

MS. TAYLOR: My name is Melanie Taylor and I represent the defendant, MAC Acquisitions.

THE VIDEOGRAPHER: You may now swear in the witness.

DANIEL HAL SILCOX, III, M.D.,
having been first duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. DEVINE:

Q. Dr. Silcox, would you give us your full name for the record, please.

1 A. Daniel Hal Silcox, III.

2 Q. And where did you grow up, sir?

3 A. I grew up in Gainesville, Georgia.

4 Q. Could you just briefly give us an
5 overview of your formal education.

6 A. I received my bachelor of arts degrees at
7 Emory University or Emory College of Emory
8 University in 1983. Completed my medical doctorate
9 degree at Emory University in 1987. Completed one
10 year general surgery internship with the Emory
11 affiliated hospitals in 1988 and then finished my
12 orthopedic surgery residency training in 1992 and
13 that again was at the Emory University affiliated
14 hospitals.

15 Practiced one year on the faculty at
16 Emory University School of Medicine and the Emory
17 Clinic. And then did a one-year spine surgery
18 fellowship again at the Emory University affiliated
19 hospitals. Completed that in 1994. And I'm board
20 certified by the American Board of Orthopedic
21 Surgery. Was originally in 1995. Been recertified
22 two other times. And I'm certified through 2025.

23 (Plaintiff's Exhibit 1 marked)

24 BY MR. DEVINE:

25 Q. Before you is a document that's marked as

1 Plaintiff's Exhibit 1 for Silcox. Do you recognize
2 that document?

3 A. It is my curriculum vitae. And it needs
4 updating but it is January 1st, 2015. And
5 otherwise it is accurate.

6 Q. What additions would need to be made to
7 bring it up to date?

8 A. Some speaking and in-progress research.

9 Q. What is your area of specialty within
10 medicine?

11 A. Orthopedic spinal surgery.

12 Q. And could you tell the jury in a little
13 bit more detail what you do as an orthopedic spinal
14 surgeon.

15 A. So I treat all disorders of the spine.
16 Those could be infections, tumors, fractures,
17 degenerative processes which include something
18 called spinal stenosis as well as disc herniations,
19 deformities such as scoliosis, and other
20 deformities that probably are esoteric and not
21 necessarily. But all forms of spinal problems both
22 surgical and mainly nonsurgical.

23 Q. And in this particular matter what area
24 of your expertise came into play with regard to
25 David Walker?

1 A. So I treated Mr. Walker for a cervical
2 spine problem or a neck problem. And how specific
3 do you want me to get with that? I'm sure you're
4 going to ask me other questions.

5 Q. Yeah. I'll elaborate on that. When did
6 you first -- and feel free to refer to any of the
7 medical records that you have here at Peachtree
8 Orthopaedic Clinic -- but when did you first see
9 Mr. Walker?

10 A. I first saw Mr. Walker July 26th, 2013.

11 Q. And how did he come to be a patient of
12 yours at that time?

13 A. He was a second opinion consultation that
14 was requested by one of my partners, David Schiff.

15 Q. And what did you understand the nature of
16 Mr. Walker's issues to be?

17 A. He was complaining of right upper
18 extremity numbness and pain.

19 Q. And by that would be the right arm,
20 shoulder? What does right upper extremity mean?

21 A. That would include anywhere from the neck
22 going down through the shoulder and down the arm to
23 the hand. He also had a complaint of neck pain as
24 well.

25 Q. Were you able to review the records to

1 determine what sort of treatment he'd received for
2 that condition and for how long?

3 A. Yes. And my note does not tell me how
4 long as far as some of the treatment. But he had
5 utilized physical therapy, massage, he had had I
6 believe two epidural steroid -- excuse me, two
7 steroid packs as well as epidural steroid
8 injections. I'm not quite clear as to the number
9 of epidural steroid injections. I'd have to look
10 back through the notes to verify that.

11 But he had undergone what we would
12 consider to be appropriate treatment for his
13 complaints and those are somewhat algorithmic, so
14 you start with the simplest and you start moving to
15 the more elaborate. And he was coming to me
16 because he had failed to improve with those
17 conservative types of treatment and Dr. Schiff
18 wanted to see if surgery was an appropriate option
19 for him.

20 Q. And what did you do to answer the
21 question as to whether surgery was an appropriate
22 option?

23 A. So the decision to have surgery is based
24 on the patient's symptoms and then also the
25 objective findings which include physical exam

1 findings as well as those of plain x-rays and MRIs.
2 And so I put him through the physical examination
3 and found that he had some findings consistent with
4 irritated nerve roots on the right side of his
5 cervical spine.

6 Specifically in my notes are something
7 called a Spurling sign which is when we lean the
8 patient's head back and then tilt it to the side.
9 And what that does is it actually closes down the
10 passageway for some of the nerves. And if it
11 recreates their pain, that is indicative of someone
12 that has an irritated nerve root.

13 He also had some decreased sensation in
14 the right arm in the area of the C6 and C7 nerve
15 roots which basically are these fingers here, a
16 little bit of the fourth finger. So a very
17 predictable pattern of complaints that fit with the
18 subsequent findings of the MRI which were of what
19 we call disc osteophyte complexes. That's a term
20 to say that there's some bone spurs and bulging
21 discs that were narrowing the passageways for the
22 nerves on the right-hand side at the C5-6 and C6-7
23 levels. And you can interject questions as you
24 like in there.

25 Q. The next question I had is do you have

1 any MRIs that are available to you to help
2 illustrate or help the jury better understand what
3 was going on with Mr. Walker at this time?

4 A. So I do have an MRI from June of 2013.
5 If you can bring that up.

6 Q. Tell us what an MRI is while we're doing
7 that.

8 A. So MRI means magnetic resonance imaging.
9 It is basically is a powerful magnet that makes the
10 atoms -- and I won't get into the specifics -- in
11 our body kind of change direction so that -- anyway
12 it creates a picture of the inside of the body.

13 Q. You want to pull up the particular image
14 that you believe will help you to better explain
15 what was going on with Mr. Walker in June of 2013.

16 A. So this is the MRI of Mr. Walker dated
17 June 12th, 2013. And so can the jury see the
18 picture I'm looking at right now?

19 Q. Yes. And where you show the cursor, it
20 serves as a pointer.

21 A. So this is actually the tongue of
22 Mr. Walker. This is underneath of his chin, the
23 front of his neck. This goes down to his chest, so
24 this is the back of his neck. So it is a side
25 view. These are the bones in the neck: C2, C3,

1 C4, C5, C6, C7. So there's seven cervical
2 vertebrae. The first one is very hard to see for
3 almost everyone on an MRI. And then these are the
4 thoracic vertebrae down here.

5 This is the spinal cord, this dark
6 structure that looks like a long snake. The very
7 bright white around it is called cerebrospinal
8 fluid. So the spinal cord and the brain, and this
9 is part of the brain called the cerebellum, are all
10 floating in this fluid.

11 The discs are the dark areas in between
12 the bones. And so the white fluid gives an
13 excellent contrast to see if any disc is actually
14 protruding out. And what we can actually see
15 here -- and I'll enlarge this -- is that this is C5
16 and this is C6. You can see how the disc bulges
17 out some here. Bulges by themselves are not
18 particularly worrisome and they're part of the
19 aging process.

20 As we go to the -- and I'm actually
21 moving the picture and this is slicing through the
22 spine from left to right, so I'm moving towards the
23 right. You can see the bulge gets a little bigger.
24 And I get out here and you can see bulge of disc.
25 And when I said disc osteophyte, you can see how

1 there's a little white spike of bone because again
2 this is the C7 vertebra. This is C6. There's also
3 a little spike of bone off of C6. And then there
4 are also little bones here at C5-6.

5 The dark here is either disc material or
6 it is bone, but it appears to be more disc-like
7 given the fact that you can see very clearly a bone
8 spur. But that's going off to the right. And if
9 we go even further, you can still see this is
10 getting out into what's called a foramen which is a
11 hole that a nerve exits out of.

12 So we'll look at this other picture on
13 the other side. This is a little harder for most
14 people to understand, but I already told the jury
15 that this area here is the spinal cord and the
16 white around it is fluid. So this is a
17 cross-sectional view. This is Mr. Walker --
18 looking at Mr. Walker's neck as if we could cut him
19 in two and look up towards the top of his head. So
20 this is the front of his body, this is the back of
21 his body, this is the right, and this is the left.

22 And so if we're looking at this, this
23 shows where a nerve is coming out on the right and
24 where a nerve is coming out on the left and the
25 spinal cord is floating in this fluid. And this

1 looks completely normal here. This is up very high
2 in his neck.

3 As we come down we'll see other areas
4 where the nerves are exiting out. This is at C3-4,
5 so that's the space between the third and the
6 fourth bone. And we'll come down to C4-5 which is
7 here and we can see the spinal cord. It looks a
8 little bit different. It is not quite as oval as
9 it was above. There's a little bit of narrowing
10 over on the right-hand side and that, again, is
11 probably a bone spur. It is fairly small.

12 We'll come on down further and we'll get
13 to C5-6 and we'll see that this level there's more
14 bone spur all over here on the right-hand side and
15 there's even a little central bone spur or bulge of
16 the disc that causes the spinal cord to look like
17 it is a little kidney bean maybe instead of a nice
18 oval shape. I'll go back up to where it looks
19 completely normal, it is oval shaped there. Come
20 back down to this and it looks a little like a
21 kidney bean.

22 So we come down further to C6-7 and now
23 you can see there's actually a large disc or bone
24 spur protruding on the right-hand side. Again,
25 this is the right, this is the left. The spinal

1 cord is a little bit compressed and displaced
2 there. And then as we come down further it opens
3 up although there's a little bone spur also seen at
4 C7-T1, so that's the space between the end of the
5 cervical spine and the beginning of the thoracic
6 spine.

7 Q. Now, were his complaints more on one side
8 than the other? And if so, which?

9 A. So again, he presented with complaints of
10 neck pain and right upper extremity numbness and
11 pain. And so this right-sided pathology or problem
12 is consistent with his complaints. And even more
13 so the C7 nerve root comes out through this hole
14 that's narrowed at C6-7. And if I go back up to
15 the C5-6 level, the narrowing here and what looks
16 like maybe even a disc herniation there, the C6
17 nerve root would be irritated at that level and he
18 also has symptoms as well as decreased sensation in
19 the distribution of the C6 nerve root.

20 So ultimately his physical exam findings
21 correlated with irritation of the C6 and the C7
22 nerve roots on the right-hand side and he had
23 radiographic, which meaning the MRI, findings that
24 were consistent with his complaints. So with those
25 findings and with his history of having failed to

1 improve with conservative care as well as his
2 ongoing symptoms of pain, surgery was an option for
3 him in order to get long-term relief of his
4 symptoms.

5 Q. What were his other options in say this
6 time frame June, July, August of 2013?

7 A. So in the most simplistic way he really
8 exercised all options other than continuing to do
9 physical therapy exercises on his own which because
10 at some point seeing the therapist really outlives
11 its practicality. And/or what that means is
12 basically live with it and just tolerate pain and,
13 you know, that is an option for everyone.

14 Q. And what advice did you give him
15 regarding the possibility of going forward with
16 surgery after you had done the workup on him?

17 A. I'm not certain what you're asking.

18 Q. Well, basically after you had done the
19 workup with him and said what his options are, did
20 you give him any advice or how does that work? How
21 did that work with Mr. Walker?

22 A. So I tell all my patients I can't feel
23 your pain, so it is really up to them. If their
24 pain -- my goal is to educate them as to what I can
25 do and then it is up to them to decide whether they

1 wish to proceed with surgery or not. And that's
2 going to be dictated based on your symptoms. So if
3 your symptoms are bad enough, I presume you'll
4 choose to have surgery. If your symptoms are not,
5 then my guess is you'll come see me if you need me.

6 Q. I think your notes show at some point you
7 essentially gave him that option. And what did he
8 ultimately decide to do?

9 A. Ultimately he decided to have surgery.

10 Q. Have we looked at any videotape that
11 fairly and adequately shows the type of surgery
12 that you were proposing for and ultimately did on
13 Mr. Walker in early August of 2013?

14 A. We have.

15 Q. I am going to bring up clip number 1 from
16 the surgery and ask you to -- well, first let me
17 ask you before you start, have you had a chance to
18 look at this video and determine whether it fairly
19 and adequately represents the kind of surgery you
20 did with Mr. Walker?

21 A. I have. Although what it will show is a
22 single level surgery and he had a two-level
23 surgery.

24 Q. Well, with that variation does this video
25 fairly and adequately show the type of surgery that

1 you did with Mr. Walker?

2 A. Yes.

3 Q. Let's go ahead and start the clip.

4 A. Would you like me to narrate?

5 Q. Yeah. Tell us if you will what we're
6 looking at.

7 A. So we are looking at the front of the
8 cervical spine minus all the muscles, arteries,
9 veins, the esophagus, trachea, all the other
10 things. So we're looking at just the bony anatomy.
11 And then you can see the disc I guess again my
12 cursor shows up here.

13 Q. Yeah, your cursor will show.

14 A. These are the disc spaces. This is
15 considered a relatively normal disc, normal disc,
16 and then this disc has degenerative changes. The
17 disc is not as tall. These kind of areas that look
18 like little undulations are actually bone spurs on
19 the front of the spine.

20 Q. Let's roll and you continue to tell us
21 what we're looking at.

22 A. So we're getting a closeup view. These
23 are little pins that are put into the bone to be
24 able to then distract or spread apart the disc
25 space.

1 Q. And what's the purpose of that?

2 A. So as you can see, it is a -- well, it is
3 a very small space. Most discs are anywhere from 4
4 to maybe 7 millimeters in height normally. As the
5 bone spurs and all are created, that space gets
6 even more narrowed. So we distract the bones to
7 open up the space so we can do the surgery to be
8 able to remove the disc material.

9 Q. We'll roll on. Oops, I hit it too hard.
10 Let's let it roll to the end of the clip. Let's do
11 the second clip then.

12 Tell us what we're looking at here. Go
13 ahead.

14 A. So go ahead. Yeah. Hit that and
15 we'll -- so this simplifies the surgery as if we
16 could just pick the disc out. You actually have to
17 excise it. And then that showed the disc having
18 been removed. This is an actual intraoperative
19 picture. This is not Mr. Walker. This is another
20 patient from Dr. Cornman?

21 Q. Cornman I think it is.

22 A. I'm Southern. I've got marbles in my
23 mouth, so it is sometimes hard for me to say
24 things.

25 Q. Can you tell us what we're looking at

1 here.

2 A. So he's actually excising the actual disc
3 material. So what you're looking at, this is
4 actually the bone of C5 I believe in this case and
5 this would be C6. The disc material is in here.
6 And as he moves it, you'll be able to see it is
7 soft tissue. The disc is soft tissue. You can see
8 the soft tissue moving. He's using a scalpel blade
9 to actually cut that out. And then he'll use
10 what's called a pituitary rongeur to grab the disc
11 material and remove it.

12 This is the animated version of showing
13 removal of bone spurs. And then he'll actually
14 show dusting off those bone spurs. This is a
15 little out of order since he already removed disc
16 material. So typically you can remove the bone
17 spurs when you like. I usually do it towards the
18 end of the surgery, not at the beginning. So that
19 is showing now the disc is completely bone. He's
20 going to --

21 Q. What is this instrument being used?

22 A. This is a drill with a little it is a
23 cutting burr on the end. It actually is going to
24 be able to level out the bone so that the bone
25 graft material used in this particular surgery can

1 be set into the disc space. Because obviously once
2 you remove the disc, something has to go back in
3 place of it. So in this case they're going to take
4 a piece of bone and put in there.

5 And you want a flush fit between the
6 pieces of bone that exist, namely Mr. Walker's bone
7 in his case, and then the pieces of bone will fit
8 flushly to his bone and the artificial bone or the
9 bone from the patient or in the case of Mr. Walker
10 a plastic polymer spacer will fit flushly to the
11 bone, so keep going and we'll see that.

12 So again they're dusting off the edges of
13 the bone. He's going to do some more work. I use
14 a different instrument to do this but the result is
15 the same and that is burning off the ends of the
16 bone and then taking off the last bit of cartilage,
17 cartilaginous material in the back of the disc.

18 Q. Then we'll pick up with the third clip.

19 A. So I think in this particular case he's
20 using probably at this point a diamond burr. So
21 that's like a very, very fine sandpaper. It is
22 hard for me to tell for certain because the burr is
23 moving. But he's preparing it and he's going to
24 trial at some point here a spacer.

25 Q. What's going on?

1 A. He's irrigating there to get rid of what
2 we call the treatis, that is the little shavings
3 and all, you want to get those out of there because
4 they're not viable at that point and it decreases
5 the risk for infection if you'll irrigate that out
6 and get it cleaned out. So he's just sucking up
7 the irrigant.

8 Q. Now, what's the white in the bottom of
9 this picture?

10 A. So this looks like some residual disc
11 material. So as a surgeon I'm not certain what the
12 initial pathology was, that is the reason for this
13 surgery. But I wouldn't actually clean all this
14 out myself. I would leave that back there. But
15 again, I don't know exactly what the reason for the
16 surgery was other than it looked like it was an
17 unstable disc space. He's going to take a trowel
18 which is a metal piece and he's trying to size what
19 size piece of bone needs to actually go in there.
20 So again, these are pieces of disc. I do not see
21 the spinal cord actually exposed through his
22 surgery.

23 Q. So the spinal cord is below that?

24 A. Yeah. So this looks like the posterior
25 longitudinal ligament. It is a ligament on the

1 back of the spine that's in between the spine and
2 the spinal cord. This just depicts the spacer
3 going in there, the trial spacer, and it is trying
4 to match his normal disc height after having burred
5 off the bone itself.

6 Q. It says Proper Distraction there. What
7 does that mean?

8 A. So again, trying the match up the height
9 of the disc space to a more normal-looking disc.
10 But obviously he's flattened out the bone so it
11 will not be wedge shape like the normal disc. It
12 will be more block shape.

13 So this is the surgeon putting in the
14 piece of bone and he's actually using a small
15 hammer to impact it into the disc space. But this
16 was the point I was trying to make. Again, this is
17 a tamp. So he's actually pushing it into the disc
18 space. But you can see the flush fit between the
19 two bony surfaces. That looks very nice.

20 Q. What are we looking at here?

21 A. So this is a titanium plate. So these
22 bones have to grow together. And bones heal better
23 if they're not moving independently. So that
24 hence, if you break your arm, you're put into a
25 cast or your leg, you get a metal plate and screws.

1 You hold the two broken ends of the bone together
2 so they'll grow together. And likewise, in a
3 fusion this is holding the bone above and below
4 still to allow this bone graft to incorporate into
5 the existing bone.

6 Q. And what affixes the plate to the bone?

7 A. The screws. So this green here is a
8 screw that's being placed into the vertebral body
9 of C6. And it will take four screws, two into C6
10 and then two screws will go into C5.

11 Q. And in Mr. Walker's case how would you
12 compare this plate to the one you used in his
13 surgery?

14 A. So similar except for obviously this is
15 just immobilizing two bones and he had three bones
16 immobilized, so there would be a longer plate with
17 two extra screw holes.

18 Q. What's the function of the round piece?

19 A. In the middle here?

20 Q. In the middle there, yeah.

21 A. That's a locking mechanism. So once
22 these screws are in, they will tighten this down
23 and it will -- there's a little ring there that
24 will actually lay over the screws that were put in
25 to lock them in so they can't back out. Now, I say

1 can't back out. Except for what, death and taxes,
2 nothing is guaranteed. So screws can still back
3 out in spite of that nice little invention.

4 Q. Now, do you know whether you have an
5 image that shows postsurgically what Mr. Walker has
6 in his neck after you finished?

7 A. So we have an MRI from ...

8 Q. I think we're pulling that up for you
9 here.

10 A. So this is a follow-up MRI dated
11 July 13th, 2015, so almost two years from the time
12 of his surgery. And so we get similar images to
13 what I was showing the jury before. So here we
14 have this same image of the slice. So here's the
15 spinal cord again, here are the vertebra. And so
16 disc spaces in between and now you can see this is
17 C5. This has turned into bone C6 and then C6-7 has
18 turned into bone. The protruding discs are
19 completely gone back here although he does have
20 a -- at that time he was having some other symptoms
21 and he had a disc herniation below at C7-T1.

22 Q. I'll get into those in just a minute. Do
23 we have an image that shows the plate that you put
24 in during the surgery?

25 A. Well, this does. You have to -- we

1 probably do have a plain x-ray, yeah. I don't know
2 that this will show the -- let me find one here
3 that will be ...

4 Q. I think that may be it.

5 A. I was trying to get one a little further
6 out. This shows the little plate that's, as I
7 said, encompasses three levels. So this is the
8 screws into C5, 6, and 7. And this particular
9 picture is about six months after his surgery, so
10 you can see how this is turning into bone inside of
11 the disc space.

12 I think I have one other picture that may
13 be a little bit farther down the line. Extra
14 pictures in here. So this actually shows the
15 subsequent fusion that formed how this has
16 completely turned into bone. So the little spacers
17 or these little markers, the plastic does not
18 really show up otherwise because it is plastic.
19 The metal screws otherwise are shown in the bone
20 and then, as I said, the bone that's been formed
21 and joined together C5, C6, and C7. So this is a
22 successful fusion.

23 Q. What's the date of the image you're
24 looking at now, Doctor?

25 A. August 12th, 2014, so it is right at a

1 year after his surgery.

2 Q. Now, you mentioned a moment ago that
3 after the surgery you followed him and what did you
4 find was the results of the surgery?

5 A. So he had improvement following surgery.
6 I have to kind of dig through notes here. So it
7 looks like follow-up notes from September 11th,
8 2013, which was right after surgery, he was doing
9 relatively well at that point. Kind of some normal
10 postoperative complaints, still hurting some but
11 his right upper extremity pain was gone. He was
12 just having mainly neck pain at that point.

13 On October 23rd, 2013, which is a
14 three-month follow-up visit, he continued to have
15 some posterior neck pain and pain in his trapezius
16 which are these muscles up on the shoulders. He
17 was noticing his range of motion was picking up.
18 And we basically were making him go to physical
19 therapy to improve his range of motion.

20 January 15th, 2014, which is one of the
21 x-rays I showed postoperatively, showed his fusion
22 to be healing well. He was forming bone well. And
23 as far as symptoms go, it says that the pain he had
24 had in his neck and his trapezius region had eased
25 up a bit. That was my PA dictating that. That's

1 maybe loose vernacular for being better.

2 And then I think we changed to a
3 different record system, so give me a second to
4 find the note there. Apologize. These are not
5 easy to rifle through.

6 I tell you what, I'm going to paraphrase
7 because it is hard to find the dates on all these.

8 Q. All right.

9 A. So by and large he did continue to
10 improve. The one year follow-up I believe he was
11 doing reasonably well. And then he began to have
12 some increased symptoms of neck pain I believe late
13 in two thousand -- I have to look back here at the
14 date. May have been early 2015. Subsequently
15 though he had that other MRI done.

16 Q. In July of 2015 I believe you said.

17 A. Or it may have been in August. Anyway
18 but it was about two years out from his surgery.

19 Q. Right.

20 A. And we got an MRI which showed him to
21 have developed a disc herniation at the -- has this
22 got the date? Yeah. It was July 13th, 2015, so
23 almost two years out from his surgery and he had
24 developed a small disc herniation at C7-T1.

25 Q. Now, tell me what that comes from in your

1 opinion, Doctor.

2 A. So he did not report any particular
3 injury so --

4 Q. In 2015?

5 A. Correct. So one would have to assume
6 that to some degree the preexisting degenerative
7 changes put him at an increased risk for
8 subsequently through an attritional kind of just
9 wear and tear process he got that small disc
10 herniation. And he did I believe receive an
11 epidural steroid injection from my partner David
12 Schiff at that time.

13 Q. And we're going to ask him about that.
14 In your experience is there any effect at all on
15 adjacent joints above and below where a fusion
16 occurs?

17 A. So the -- yes, there is. And the medical
18 literature would suggest that there is a risk
19 that's probably in the 10 to 15 percent, maybe even
20 some reports would be even higher than that,
21 20 percent chance that you can get adjacent segment
22 degenerative change, maybe symptomatic, maybe not
23 symptomatic.

24 So we know that does happen. As to why
25 it happens is still unclear because -- but there

1 are artificial discs that exist which retain motion
2 and yet people wear out above and below artificial
3 discs as well, so there appears to be some genetic
4 component that's part of this. So we don't know
5 for certain why people will wear out although I
6 think a lot of us feel the stiffness of a fusion
7 probably does push the risk to wear out above or
8 below but it is not clearly understood.

9 Q. You mentioned symptomatic and
10 nonsymptomatic. What do you mean by those terms,
11 if you would elaborate?

12 A. So again, degenerative changes occur with
13 everyone. I got gray hairs, you have some.
14 There's a few others who may have some and then a
15 lot of people who don't. But the point being is we
16 all degenerate, we all wear out. So x-rays
17 document that well. But that doesn't mean you
18 necessarily hurt. So someone who is asymptomatic
19 doesn't hurt but does have degenerative changes.
20 It does also in part the fact that they're perhaps
21 more likely to be injured than someone who doesn't
22 have degenerative changes.

23 Q. Tell me what you mean by that, someone
24 who's got degenerative changes is more likely to
25 suffer or be hurt than one who doesn't.

1 A. Well, I think logic would dictate that to
2 a great degree. I think when you and I talked
3 earlier I said we don't see old football players
4 playing because they get injured more easily. And
5 why is that, it is just the wear and tear change to
6 their body through the years they're more
7 susceptible to being injured. Now, granted they're
8 playing football. But it even goes for those of us
9 if I go out at age 55 and start doing some really
10 hard yardwork, I'm more likely to herniate a disc
11 in my back by just doing yardwork than my
12 19-year-old son and that's because I'm wearing out
13 for better or for worse. So we just have to keep
14 that in mind that as we age and we have
15 degenerative changes, we are more prone to injury.

16 Q. Now, Mr. Walker in March of 2013 was in
17 his mid forties. Based on the view of his images
18 of his spine, was he in your view have more or less
19 or about normal level of degenerative changes for
20 someone his age?

21 A. Relatively normal.

22 Q. You are also familiar I assume with the
23 fact that he'd had some history of problems
24 including even a surgery in his low back or lumbar
25 area down by his waist?

1 A. I was aware of that, yes.

2 Q. How would that relate to, if at all, the
3 problems that he presented with in 2013 that you
4 saw him for after Dr. Schiff had seen him?

5 A. The lower back?

6 Q. Yes. How would the low back issues and
7 surgery, how would that affect someone with the
8 neck issues that he presented with?

9 A. I really wouldn't tie the two together.
10 So lumbar disease is -- granted you can have lumbar
11 degenerative disc disease in there or have
12 degenerative changes in the cervical spine. But as
13 far as the injury and pathology in the lower back,
14 it is so far removed from the neck there really
15 isn't a tie-in other than the genetic
16 predisposition that may exist for degeneration just
17 because of what your mom and your dad gave you.

18 Q. Right. Now, approximately how tall was
19 Mr. Walker when you first encountered him as a
20 patient?

21 A. 5 feet, 11 inches was the height he had
22 when I first saw him.

23 Q. And the weight?

24 A. 218 pounds.

25 Q. Let me ask you to assume that in March of

1 2013 that Mr. Walker went through a door at a
2 restaurant. As he opened the door his first
3 footfall beyond the door his foot went out from
4 under him, he found himself essentially up in the
5 air, both feet up in the air, and he landed in a
6 way that he was trying to protect his lower back or
7 his lumbar back and describes his feet and upper
8 body hitting the floor and him being able to keep
9 his lower body or his rump if you will from not
10 striking the floor and experiencing something like
11 whiplash in the neck.

12 Now, how would that in your opinion
13 relate to the kind of symptoms that he had when you
14 first saw him in June of 2013?

15 A. So I think we have established that he
16 had preexisting degenerative changes. And if we
17 have not, he did. Plain x-rays showed some typical
18 degenerative changes. I'll step out. I did find
19 from the other attorney here that there was an MRI
20 from 2009 that did show degenerative changes in the
21 cervical spine which were seen again in the MRI
22 from June of 2013. These produced foraminal
23 stenosis so some narrowing of the passageway where
24 the nerves are coming out at the C5-6 and C6-7
25 levels.

1 So in the case of falling and whiplash
2 where the head is thrown backwards, other times it
3 is thrown forward and then backwards. But in that
4 process a narrowed hole can become even more
5 narrowed. Just like I said earlier, one of our
6 examination things is Spurling maneuver where we
7 had the patient lean his head or her head backwards
8 and then tilt it to the side, we're closing down
9 that hole.

10 If you do that acutely with some minor
11 trauma which is essentially the slip and fall, it
12 can pinch the nerve root and in doing so, if it is
13 hard enough, create a swelling of the nerve in this
14 little hole. Very similar to having a ring on and
15 then slam your finger in the door, your finger
16 begins to swell up. If you go to the emergency
17 room, they're going cut that ring off very quickly
18 because the swelling will be only aggravated by the
19 fact that there's something obstructing the blood
20 flow in and out of the finger.

21 Much is the same here, the blood flow
22 within that foramen, that little hole, begins to
23 change as the nerve swells and it is that change in
24 the blood flow that then produces a chemical change
25 in the nerve. I'm trying to simplify that. But

1 that's what induces the pain in his arm. That can
2 also occur when someone herniates a disc and that
3 disc fills up a space which was before open for the
4 nerve to move in.

5 And again, what's it do? It creates
6 inflammation and a change in the blood flow.
7 Hence, that's why antiinflammatory medications are
8 used intended to shrink that inflamed and swollen
9 tissue. Steroids are then tried if those
10 antiinflammatories don't work again to shrink the
11 inflamed tissue. And then an epidural steroid
12 injection is putting the steroids right where the
13 problem is, again, to help shrink the inflamed
14 tissue all to help improve the blood flow in the
15 nerve root so it can return to feeling normal. And
16 of course if it won't return to being normal, then
17 that's when the patient ends up looking at surgery.

18 Q. Assuming the kind of fall that I
19 described to you occurred, how quickly would pain
20 or injury begin to be noticed by the person who
21 experienced that fall if in fact some injury
22 occurred?

23 A. It could be anywhere from, you know,
24 relatively instantaneous to it could be a few days
25 or a week or so down the road. It just depends on

1 how much obstruction of the blood flow and
2 compression in the nerve occurs acutely versus over
3 time. And again, you know, I don't know that I can
4 be anymore precise than that but that's just the
5 kind of way it works.

6 Q. If the record shows that the fall
7 occurred on March the 3rd and his first visit with
8 Dr. Schiff regarding this fall was on March
9 the 12th, would that be unusual from your
10 standpoint or within the norm? How would you
11 characterize that?

12 A. I am going to assume he called for an
13 appointment since we're not an emergency room, so
14 that would have taken a few days. So the
15 chronology events are such that you're injured and
16 you call for an appointment with an doctor you have
17 already seen and you get in as soon as I can. And
18 I think Mr. Walker would have to answer to that as
19 to how quickly he could get an appointment.

20 Q. Going now to his current situation or at
21 least when you last saw him in 2015, what was his
22 condition then and what were his options as you
23 found them and shared them with Mr. Walker?

24 A. So he was still having some symptoms.
25 And I'll try to see -- let's see. Let's see if I

1 can find my note here. You probably have it --

2 Q. July 2013 was the date of the MRI -- I'm
3 sorry, July the 13th, 2015 was the date of the MRI
4 that we looked at earlier that was about two years
5 after the surgery.

6 A. Yeah, it looks like I saw him on ...

7 MS. TAYLOR: You want me to give him my
8 copy?

9 MR. DEVINE: Yeah, if you've got one
10 handy.

11 A. With our new electronic medical record it
12 is very difficult to find notes.

13 MS. TAYLOR: I think I just found it.

14 A. Well, this is the, yeah, the MRI report
15 is July 13th. And then it looks like I saw him
16 on -- my goodness, trying to find a date on these
17 is very difficult.

18 BY MR. DEVINE:

19 Q. I think we may be able to find them on
20 the computer here.

21 A. It is 8/3/2015. I finally found it.

22 Q. August the 3rd, 2015.

23 A. Is when I saw him and that was to follow
24 up on his MRI. And at that time I talked to him
25 about the fact that he had the disc herniation at

1 C7-T1 on the right. And so this is somebody pulled
2 it up for me.

3 Q. Yeah, we've pulled it up for you to --

4 A. Go back over.

5 Q. -- show the jury what was going on in
6 July of 2015.

7 A. So when we look at this -- so this is a
8 little easier to -- this is the side view again --
9 shows the fusion that was done. And as I go over
10 towards the center, you can see down here at C7-T1
11 this is an acute or relatively subacute, meaning
12 not necessarily yesterday but within a month or
13 two, that this is a new disc herniation here at
14 C7-T1.

15 And the reason we can tell that is it is
16 kind of a lighter gray versus the black that the
17 other disc material and/or the bone here and that
18 means it has got some inflammation in it. This
19 cross-sectional view is easier to see here because
20 it shows the teeth and his jaw. So again, this is
21 front, this is back, right, left.

22 And as we come down to this disc level
23 and you can see part of his fusion here. We get
24 down to C7-T1. And again, this is the right side,
25 this is the left side. You can see this protrusion

1 or herniation that is on the right-hand side at
2 C7-T1.

3 Q. What are now and have been since you saw
4 him in July and August of 2015 are options for
5 Mr. Walker to deal with this disc herniation at
6 C7-T1?

7 A. So at that time I believe I offered up to
8 him to get an epidural steroid injection with
9 Dr. Schiff. And then I think he did have a nerve
10 test done also with Dr. Schiff. The long and short
11 of it, I ended up telling him if he was bothered by
12 his symptoms enough, then additional surgery could
13 be done either as a what we call laminoforaminotomy
14 because the disc herniation is off to the side and
15 in an attempt to avoid a fusion at that level we
16 could just take the disc herniation out and open up
17 the little hole for the nerve or the other would be
18 to look at a fusion at the C7-T1 level. So either
19 type of surgery would help relieve his pain.

20 And again, the decision to have surgery
21 would be based on his symptoms as well as the
22 findings that were then --

23 Q. Right.

24 A. Of course at this point he's far enough
25 out he would need to have a new MRI to verify that

1 it is still reasonable to undergo surgery.

2 Q. Did you think that surgery was a
3 reasonable option for him as early as August of
4 2015?

5 A. I think in August 2015 I was like try the
6 epidural first --

7 Q. Right.

8 A. -- because symptoms can resolve.

9 Q. Right.

10 A. If they did, then no surgery would be
11 necessary.

12 Q. Do you have an opinion as to whether the
13 disc herniation at C7-T1 that he's currently
14 dealing with has any causal connection to a fall on
15 March the 3rd, 2013 at the restaurant?

16 A. There was a previous little bone spur out
17 here on the right. But in comparing to two MRIs,
18 this is a noticeable change that occurred. So I
19 cannot say directly it was caused by the fall of
20 whatever the date was, March of 2013.

21 Q. March the 3rd of 2013. But in terms of
22 the symptomatology that he's experiencing and the
23 surgery that you did to deal with that, is there
24 any causal connection in your opinion between
25 those?

1 A. This is probably one of the most debated
2 points of medicine is is the adjacent segment
3 disease due to the fusion or not. And it is
4 possible. I cannot say that it is probable but I
5 can say it is possible.

6 Q. Now, insofar as what his choices are as
7 we sit here today, assume for a moment that he has
8 tried the steroid injection and had the nerve test
9 done and we'll talk with Dr. Schiff about that.
10 But what would his options be going forward
11 assuming that he had another MRI and it showed what
12 we're looking at as of July 2015, that the MRI
13 confirmed that he still had that condition, what
14 would his options be now?

15 A. Really the same as I said before. So he
16 could look at a lamino -- I mean he could have
17 epidural steroid injections again, physical therapy
18 is still available. I mean he can redo those
19 conservative forms of treatment. Or if he opts to
20 move forward since he's at least had one epidural,
21 he could always elect to undergo further surgery if
22 he wished to do so.

23 Q. Or?

24 A. Live with it.

25 MR. DEVINE: Thank you, Doctor.

EXAMINATION

BY MS. TAYLOR:

Q. Hi, Dr. Silcox. Again, I'm Melanie Taylor and I just have a few questions for you. You gave us a tour of Mr. Walker's discs and bulging discs and nerves and bone spurs. You're not saying that any of those conditions were caused by the fall at Macaroni Grill, correct?

A. And I think you and I talked about this earlier is without me doing a head-to-head comparison, my impression is more likely than not the changes are more degenerative in nature although there could be acute herniation at C5-6. But I'd have to do head-to-head comparisons and I've not had the opportunity to do that.

Q. Because your first time seeing Mr. Walker was after his fall, correct?

A. It was.

Q. And your note on July 26th states that the patient told you that his symptoms started after the fall, correct?

A. Correct.

Q. You did not independently attempt to verify that or challenge it, correct?

A. That's correct.

1 Q. And you were not informed at that time
2 about any similar symptoms that Mr. Walker might
3 have had in 2009, correct?

4 A. I was not aware of any.

5 Q. Nor were you informed about any similar
6 symptoms that he had in 2010, correct?

7 A. Correct.

8 Q. And how about 2011?

9 A. Correct, I was not aware of any.

10 Q. And the purpose of your evaluation and
11 treatment was not to determine whether his fall
12 caused his symptoms or injury, correct?

13 A. That's correct.

14 Q. For the purposes of your treatment you
15 did not need to confirm that his symptoms started
16 after the fall, right?

17 A. Correct.

18 Q. So you did not need to nor did you
19 request medical records from the years prior to his
20 coming to you, correct?

21 A. That is correct.

22 Q. And you did not compare his MRIs from
23 before the fall with those of after the fall,
24 correct?

25 A. I was not aware there was one before.

1 Q. So all of that is to get to this: You
2 did not personally confirm whether Mr. Walker had
3 any of these symptoms or diagnosis before the fall,
4 correct?

5 A. That is correct.

6 Q. So in fact if Mr. Walker did have neck
7 pain or finger numbness before the fall in 2013,
8 you would not know that, right?

9 A. You're correct.

10 Q. And Mr. Walker has not returned to you
11 for treatment since October 8, 2015, correct?

12 A. That is correct.

13 MS. TAYLOR: I have no further questions.

14 EXAMINATION

15 BY MR. DEVINE:

16 Q. I have some redirect, Doctor. In terms
17 of confirming the existence of symptoms at certain
18 points in time, how would a doctor go about doing
19 that?

20 A. Number one, I would have to explore that.
21 Number two, I would have to have -- and we even
22 talked about this before -- if I know I'm going to
23 be doing a deposition two or three years later, I
24 probably would have asked the questions
25 differently. But I have to admit I think as a

1 doctor and that is not causal. It is more I'm
2 there to help the patient. And so I did not ask
3 all those questions and it is hard for him to
4 answer questions that I don't ask. Really my
5 concern for him was to help treat his symptoms.

6 Q. Right. And if a patient tells you that
7 they hurt, do you have any way to confirm or prove
8 that that's not the case?

9 A. No.

10 Q. In your experience do people come see the
11 doctor and tell you they're hurting when they're
12 not?

13 A. There are some that do.

14 Q. And what about undergoing surgery?

15 A. I hope no one would undergo surgery
16 unless they had serious discomfort. I'm not
17 certain but I would guess probably through the
18 years there's been somebody that's had surgery that
19 wanted to legitimize their complaints. But I think
20 that's a really weird unusual person.

21 Q. Yeah.

22 A. For which I will say Mr. Walker is not.

23 Q. All right. Let me ask about range of
24 motion following his surgery that you did on him in
25 August of 2013.

1 MS. TAYLOR: If I may object. I didn't
2 ask him about that.

3 MR. DEVINE: Perhaps you didn't but
4 you'll have the opportunity to redirect or recross.
5 Your objection stands.

6 BY MR. DEVINE:

7 Q. Did the surgery that you did for him
8 affect his range of motion?

9 A. The surgery would affect the range of
10 motion of a normal neck. I think we already
11 established he had some degenerative changes. And
12 unfortunately, again, I didn't examine him -- I say
13 unfortunately only because we're doing a
14 deposition -- but I didn't have the opportunity to
15 ever examine him before he had the injury, so I
16 really couldn't make comment on what kind of range
17 of motion he had before.

18 But in the sense of doing a two-level
19 fusion, it takes away about 15 percent of the
20 motion of a normal spine. So he did have some
21 motion still in those areas. So how much
22 additional loss of motion that occurred is almost
23 hard to quantify. But certainly it did occur.

24 Q. If he decides to go forward with another
25 surgery involving a fusion, would you expect that

1 to further reduce his range of motion?

2 A. It will. It will probably, again
3 assuming a normal spine, it would take away about 7
4 and a half to 8 percent of the extremes of his
5 motion. Because each disc level imparts about 7
6 and a half to 8 percent of the motion of the spine.

7 Q. And just in terms of mobility of the
8 neck, what sort of activities does that limitation
9 impact?

10 A. That's more symptom driven than anything
11 else. So I mean obviously there are some things
12 that will be more difficult. You know, if you were
13 trying to -- and I say this only because I've
14 treated professional athletes -- I did a two-level
15 fusion on a hockey player. It is very hard to
16 skate and look back when you're skating because I
17 guess we all know hockey they skate backwards. So
18 that makes it more difficult for things like that.
19 But knowing that he's not going to do that.

20 But otherwise, no symptoms of pain means
21 he can participate in anything he likes. And the
22 flipside is is, you know, Peyton Manning had a
23 single level fusion in his neck and he won the
24 Super Bowl. So a fusion in and of itself can
25 impart significant stability to the neck to allow

1 someone to resume their normal activities. But
2 again, it has to be symptom driven. If you got
3 symptoms of pain, then I presume you'll use that
4 information and not do whatever activity is that's
5 causing the pain. Makes a lot of sense. On the
6 other hand, if you don't hurt, then by all means do
7 whatever you like.

8 MR. DEVINE: Understood. Nothing
9 further.

10 MS. TAYLOR: Nothing further.

11 THE VIDEOGRAPHER: This concludes the
12 video deposition of Dr. Daniel Silcox. We're off
13 the record at 5:36 p.m.

14 (Deposition concluded at 5:35 p.m.)

15 (Signature waived)
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1 The following reporter and firm disclosures
2 were presented by me at this proceeding for review
3 by counsel:

4 REPORTER DISCLOSURES

5 The following representations and disclosures
6 are made in compliance with Georgia Law, more
7 specifically:

8 Article 10 (B) of the Rules and Regulations of
9 the Board of Court Reporting (disclosure forms)

10 OCGA Section 9-11-28 (c) (disqualification of
11 reporter for financial interest)

12 OCGA Sections 15-14-37 (a) and (b)
13 (prohibitions against contracts except on a
14 case-by-case basis).

15 - I am a certified court reporter in the State of
16 Georgia.

17 - I am a subcontractor for Veritext Legal
18 Solutions.

19 - I have been assigned to make a complete and
20 accurate record of these proceedings.

21 - I have no relationship of interest in the matter
22 on which I am about to report which would
23 disqualify me from making a verbatim record or
24 maintaining my obligation of impartiality in
25 compliance with the Code of Professional Ethics.

- I have no direct contract with any party in this
action, and my compensation is determined solely by
the terms of my subcontractor agreement.

FIRM DISCLOSURES

- Veritext Legal Solutions was contacted to provide
reporting services by the noticing or taking
attorney in this matter.

- There is no agreement in place that is prohibited
by OCGA 15-14-37 (a) and (b). Any case-specific
discounts are automatically applied to all parties,
at such time as any party receives a discount.

- Transcripts: The transcript of this proceeding
as produced will be a true, correct, and complete
record of the colloquies, questions, and answers as
submitted by the certified court reporter.

- Exhibits: No changes will be made to the
exhibits as submitted by the reporter, attorneys,
or witnesses.

1 - Password-Protected Access: Transcripts and
2 exhibits relating to this proceeding will be
3 uploaded to a password-protected repository, to
4 which all ordering parties will have access.
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CERTIFICATE

STATE OF GEORGIA:

COUNTY OF FULTON:

I hereby certify that the foregoing transcript was taken down, as stated in the caption, and the colloquies, questions and answers were reduced to typewriting under my direction; that the transcript is a true and correct record of the evidence given upon said proceeding.

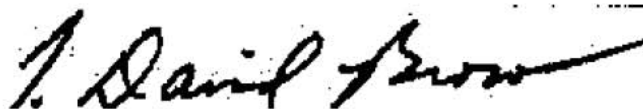
I further certify that I am not a relative or employee or attorney of any party, nor am I financially interested in the outcome of this action.

I have no relationship of interest in this matter which would disqualify me from maintaining my obligation of impartiality in compliance with the Code of Professional Ethics.

I have no direct contract with any party in this action and my compensation is based solely on the terms of my subcontractor agreement.

Nothing in the arrangements made for this proceeding impacts my absolute commitment to serve all parties as an impartial officer of the court.

This the 18th day of August, 2016.



J. DAVID BROWN, CCR-B-1401

TIFFANY ALLEY, A VERITEXT COMPANY
FIRM CERTIFICATE AND DISCLOSURE

Tiffany Alley Veritext represents that the foregoing transcript as produced by our Production Coordinators, Georgia Certified Notaries, is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the certified court reporter in this case. Tiffany Alley Veritext further represents that the attached exhibits, if any, are a true, correct and complete copy as submitted by the certified reporter, attorneys or witness in this case; and that the exhibits were handled and produced exclusively through our Production Coordinators, Georgia Certified Notaries. Copies of notarized production certificates related to this proceeding are available upon request to litsup-ga@veritext.com.

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